STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

07/95 f. DSH Adjustment Limitations.

10/93 i. Hospitals that qualify for DSH adjustments under this Chapter shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in Sections C.1. through C.4. of Chapter II., or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under Sections C.7.a. and C.7.b. shall cease effective on the date that the hospital discontinued the provision of such non-emergency obstetrical care.

10/92 ii. Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Chapter IX., which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Chapter.

07/95 iii. DSH Payment Adjustment. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Chapter do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this section shall be adjusted to meet the State DSH Allotment. This adjustment shall first be applied to DSH payments made under Section C.7.c. above. If further adjustments are necessary, then DSH payments made under Section C.7.b. above shall be adjusted, with the DSH payments made under Section C.7.a. being adjusted last.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 iv. Omnibus Budget Reconciliation Act of 1993 (OBRA '93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospital's disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustment to hospitals will be computed by determining a hospitals cost of inpatient and outpatient services furnished to Medicaid patients, less the amount paid to the hospital for inpatient and outpatient services excluding DSH payments made under this State plan. The cost of services provided to patients who have no health insurance or source of third-party payment less any payments made by these patients shall be determined and added to the Medicaid shortfall calculated above. The result shall be compared to the hospitals estimated DSH payments. If the estimated DSH payments exceed the DSH limit (Medicaid shortfall plus cost of uninsured) then the Department will reduce the hospitals DSH rate per day so that their DSH payments will equal the DSH limit. If necessary, retroactive adjustments will be made.

03/95 v. Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilizaiton rate, as defined in Section C.8.e. of this Chapter, is less than one percent.

07/91 8. Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

10/93 a. "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993, DSH determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, DSH determination year, etc.

10/93 b. "DSH determination year" means, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

== 10/93

c. "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section C.3.c. of this Chapter. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

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d. "Mean Medicaid Obstetrical Inpatient Utilization Rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in Section C.8.g. below, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below, for all such hospitals. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims database.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

10/93 e. "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et. seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in Section C.3.c. of this Chapter. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

==07/95 f. "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in Section C.8.g. below, provided by a Medicaid-participating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in Section C.8.i. below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 g. "Medicaid (Title XIX) obstetrical inpatient days" means, hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

10/93 h. "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section B.1. of Chapter VIII.

10/93 i. "Total Medicaid (Title XIX) inpatient days", as referred to in Sections C.8.d. and C.8.f. above, means, hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

10/93 j. "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 D. Public Law 103-66

==07/95 1. Public Law 103-66 Requirements

==07/95 a. Each cost reporting hospital as described in Chapter VIII, Section G, shall annually submit, on or before August 15, of the rate year, at least the following information separated by inpatient and outpatient (including hospital-based clinic services) to the Department:

==07/95 i. The dollar amount of uncompensated care charges rendered in the base year.

==07/95 ii. The dollar amount of charges rendered in the base year that are reimbursable by the Department for those program participants covered under the Family and Children Assistance Program, formerly known as the General Assistance Program (Article VI of the Public Aid Code).

==07/95 iii. The dollar amount of Medicaid charges rendered in the base year.

==07/95 iv. The dollar amount of total charges for care rendered in the base year.

==07/95 b. Definitions

10/92 i. "Medicaid charges" means hospital charges for inpatient, outpatient and hospital-based clinic services provided to recipients of medical assistance under Title XIX of the Social Security Act.

==07/95 ii. "Total charges" means the total amount of a hospital's charges for inpatient, outpatient and hospital-based clinic services it has provided.

==07/95 iii. "Base year" means July 1 through June 30 of each year beginning with July 1, 1994 through June 30, 1995.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 iv. "Uncompensated care charges" for a hospital means:

10/94 A) the hospital's charges for inpatient, outpatient and hospital-based clinic services for which the hospital was not reimbursed by either the patient or a third party (including the Department);

B) less:

10/92 1) the amount of the hospital's bad debt recoveries for inpatient, outpatient and hospital-based clinic services; and

10/92 2) the hospital's charges attributable to inpatient, outpatient and hospital-based clinic services that if provided without charge or at reduced charges under its obligation under the federal Hill-Burton Act (42 U.S.C. 291 et seq.).

==07/95 E. County Trauma Center Adjustment (TCA). Illinois hospitals that, on the first day of July preceding the TCA rate period, are recognized as Level I or Level II trauma centers by the Illinois Department of Public Health, shall receive an adjustment that shall be calculated as follows:

==07/95 1. The available funds from the Trauma Center Fund for each quarter shall be divided by each eligible hospital's (as defined in 2. above) Medicaid trauma admissions in the same quarter of the TCA base period to determine the adjustment for the TCA rate period. The result of this calculation shall be the County TCA adjustment per Medicaid trauma admission for the applicable quarter.

==07/95 2. The county trauma center adjustment payments shall not be treated as payments for hospital services under Title XIX of the Social Security Act for purposes of the calculation of the intergovernmental transfer provided for in Section 15-3(a) of the Public Aid Code.

==07/95 3. The trauma center adjustments shall be paid to eligible hospitals on a quarterly basis.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 4. Trauma Center Adjustment Limitations. Hospitals that qualify for trauma center adjustments under this Section shall not be eligible for the total trauma center adjustment if, during the TCA rate period, the hospital is no longer recognized by the Illinois Department of Public Health, or the appropriate licensing agency, as a Level I or a Level II trauma center as required for the adjustment described in Section E. above. In these instances, the adjustments calculated under this Section shall be pro-rated, as applicable, based upon the date that such recognition ceased.

==07/95 5. Trauma Center Adjustment Definitions. The definitions of terms used with reference to calculation of the trauma center adjustments required by Section E are as follows:

==07/95 a. Available funds" means funds which have been deposited into the Trauma Center Fund, which have been distributed to the Department by the State Treasurer, and which have been appropriated by the Illinois General Assembly.

==07/95 b. "Medicaid trauma admission" means those claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99, 958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the TCA rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 c. "TCA base period" means State Fiscal Year 1991, for TCA payments calculated for the October 1, 1992 TCA rate period, State Fiscal Year 1992 for TCA payments calculated for the October 1, 1993, TCA rate period, etc.

==07/95 d. "TCA rate period" means, beginning October 1, 1992, the 12 month period beginning on October 1 of the year and ending September 30 of the following year.

==07/95 e. "Trauma Center Fund" means the fund created for the purpose of distributing a portion of monies received by county circuit clerks for certain violations of laws or ordinances regulating the movement of traffic to Level I and Level II trauma centers located in the State of Illinois. The Trauma Center Fund shall also consist of all federal matching funds received by the Department as a result of expenditures made by the Department as required by Section E.4.

==07/95 F. Medicaid High Volume Adjustments (MHVA)

==07/95 For inpatient admissions occurring on or after October 1, 1993, the Department shall make Medicaid High Volume Adjustments (MHVA) to hospitals.

==07/95 1. Criteria. To qualify for MHVA adjustments under this Section, hospitals must meet the following criteria:

==07/95 a. Be eligible to receive the adjustment payments described in Section C. of this Chapter in the MHVA rate period;

==07/95 b. Not be a county-owned hospital, as described in Section A.1.a.i. of Chapter XVI., or a hospital organized under the University of Illinois Hospital Act, as described in Section A.1.a.ii. of Chapter XVI., in the MHVA rate period; and

==07/95 c. Not be a facility operated by the Department of Mental Health and Developmental Disabilities, as described in Section A.7. of Chapter XVI.

STATE OF ILLINOIS

METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG) AND MEDICAL ASSISTANCE-NO GRANT (MANG)

==07/95 2. Calculation of Medicaid High Volume Adjustments

==07/95 a. Hospitals meeting the criteria specified in Section F.1. above shall receive a MHVA payment adjustment of $60.

==07/95 b. For children's hospitals, as defined in Section C.1.e. of this Chapter, the payment adjustment calculated under Section F.2.a. above shall be multiplied by 2.0.

==07/95 c. The amount calculated pursuant to Sections F.2.a. and F.2.b. above shall be adjusted on October 1, 1993, and annually thereafter, by a percentage equal to the lesser of: